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California Medicine
THE WESTERN JOURNAL OF MEDICINE

June 1972

Reprinted From CALIFORNIA MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

Refer to: Ward PD: A review of the California RMP Program (Government and Medicine). Calif Med 116:77-80, Jun 1972

Government and Medicine

A Review of the California RMP Program

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AFTER FIVE AND ONE-HALF YEARS of life, Regional Medical Programs in California emerged as the nation's largest RMP, in both program volume and dollar support. The fifth year emerged as this region's most successful year, even though it followed nearly two years of debate and concern at the national level over what the future role of RMP as a national program should be.

During the period of national debate over the program, there was seldom any question of the validity of the original purposes of the program —to make available to the victims of heart disease, cancer and stroke, through the establishment of cooperative arrangements among existing health providers, the latest advances in treatment leading eventually to a single high quality of care available to all. There was a question, however, as to the priority this effort should receive in the allocation of the money that was available for federally funded health programs.

Early 1970 saw the establishment of a relatively firm set of national health goals which indirectly established priorities. It proved difficult for RMP, as an overall program composed of 55 separate regions, to relate immediately to these priorities since the priorities seemed to be aimed primarily at providing care for those deprived of care and essentially emphasized a noncategorical approach. The RMP authorizing legislation was considered by some national figures as too narrow in scope to get at the nation's basic high priority health needs. The 55 RMP regions had to reassess their position and determine what role, if any, they could play in meeting these newly identified priority health needs.

The fact of the matter was that most of the successful regions were already coping with several of the problems identified in the national health goals. This effort had not received the attention that other aspects of the program had. Subsequently, there was a significant effort on behalf of the program by national leaders of the medical profession, hospital and voluntary association leadership, and members of local RMP advisory groups to make this fact known.

To some, this signified an abrupt change in the direction of the evolution of the program. To those more familiar with the program, however, it appeared only as an added emphasis on one aspect of the program that had been in existence since its inception.

The fact became obvious early in the planning phase that there was maldistribution of services in some instances, and in these cases it was impossible to plan improved services for heart disease, cancer and stroke if there were inadequate basic services. It was for this reason that some of our first projects were non-categorical in nature and tended to serve the basic medical needs of all patients in certain underserved areas. RMP's early efforts in Watts in conjunction with the King Hospital is a case in point.

As these facts became better known and understood, support for the program grew. There was a distinct turnaround in the outlook on funding for the program. Regions had received cuts in their funding a year earlier, but during recent months additional funding has become

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available on a merit basis. The California RMP, to date, has enjoyed a high ranking on the merit scale for the quality of its program and in this year alone has had three increases for a total of better than a 40 percent increase in total program dollars.

The California RMP obtains its policy and program direction from a consortium of health providers, voluntary associations and lay members formed into a non-profit corporation known as the California Committee on Regional Medical Programs (CCRMP). As of this writing, its corporate membership amounts to 27 professional persons, as representatives of various institutions, professional and voluntary associations, to which public members are added to form the regional advisory group. The legal grantee is the California Medical Education and Research Foundation which, in turn, delegated program and policy responsibility to CCRMP. CCRMP sets the goals and objectives and approves program expenditures, thus determining the direction that the program will take. CCRMP has watched with interest the goals set at the national level but, at the same time, has worked to protect the integrity of its own predetermined concepts of what the program direction should be.

The recent past direction of the California RMP can be seen in our report to the RMP National Advisory Council for continued funding for this fiscal year. At that time (first six months of fiscal 1971), we reported that our total project dollars were spent as follows:

	No. of Activities	Percent of Total Dollars
PURPOSE: To increase the		
1) Quality of individual acts of medical care	70	77.3
2) Accessibility of medical care	5	9
3) Availability of medical care	4	.3
4) Acceptability of medical care	1	.4
5) Quality and availability of medical care	3	3
6) Other activities which contain elements of all the above purposes	3	10
TOTALS	86	100.0

The percentages were determined by breaking each project into its various activities, classifying the activity as to what it was intended to produce, and then weighting its cost against the total project dollar expenditure. Purpose 1 (in the list above), which represents essentially continuing education, training and retraining in their broadest interpretations, is the dominant thrust of the program. This report was subjected to review by a site visit team which reviewed each project, and to further staff review. No question was raised about the validity of this approach.

Although the programs and activities have significantly increased this year, essentially they are built on our early experiences. California RMP, like programs in other regions, began with a heavy emphasis on the development of coronary care units (CCU). Training physicians and nurses to manage and operate the units was the principal RMP function, but consultation and other services were provided hospitals and their staffs in the development of the coronary care units. Certainly RMP was not responsible for all the CCUs that were created, but through the establishment of the statewide CCU committee and the Confederation of Coronary Care Units where data could be collected and standards of care discussed, RMP did have a direct effect upon the acceleration of this service. It was reported that during this period the number of CCUs increased from 11 in 1966 to more than 250 in 1970.

Early in the course of CCU projects, at a meeting in which we were considering ways to strengthen the then operational training programs, the discussion was interrupted by a practicing cardiologist from a small Northern California community. He said the training programs were good and seemed to accomplish their goals, but an essential point was being overlooked. In his hospital, he said, the chief virtue of CCU training was a boost in morale throughout the whole nursing staff and a decided increase in activity of all the in-service teaching.

The same kinds of reports came from other hospitals as well. And, as the program continued, other benefits were seen. The primary target was training, but regionalization of the training programs made it possible to compare all CCU work, shore up weak points and exchange experience on successes. Finally, what started as a practical manpower training application of advanced research in the care of heart disease led to providing information and putting it back into the channels of research for others to pursue. The cardiologists who directed our CCU training projects were able to set in motion

research, not carried out by us, into the most effective ways of treating myocardial infarctions.

The CCU experience led to the development of one of the region's most sought after training experiences which was descriptively entitled, "The Training of Physicians in Eleven Skills of Intensive Care." Carried out under the aegis of Pacific Medical Center and UCSF Medical School, the program provides on-site training, electronics consultation, electrical safety, acute care nursing and other related matters. As the program develops, more of the training is being accomplished at the local level and, as in the case of CCU training, it is hoped that the major portion will be assumed by community hospitals and colleges.

Our efforts in improving cancer care did not materialize as rapidly as did the CCU program. There were at least two major reasons for this. First, CCUs were at a technological stage capable of rapid expansion and, therefore, received early attention. Second, just as the cancer planning was gaining momentum, funding for the program diminished. Nevertheless, during the dark days of funding possibilities, there were several activities in cancer care improvement undertaken. They consisted of clinical cancer consultation services to outlying hospitals, radiological physics services to assist local radiotherapy services, a computerized data retrieval system for patient records and follow-up, and other ongoing training programs. There is need for further regionalization and improvement of services and it is hoped that funding will become available to achieve these ends.

Efforts in the category of stroke have been directed largely toward the development of stroke treatment and rehabilitation teams. Efforts to develop data collection on stroke victims have been carried forward concomitantly, and in one part of the state there is a strong drive to regionalize stroke rehabilitation services in extended care facilities by use of the mobile rehabilitation team. How to continue the impetus for these services after the expiration of RMP funds remains a perplexing problem, but out of this effort there has emerged the drive to create the United Stroke Association, a national non-profit foundation financed from private sources with the goal of drawing greater national attention to the stroke victim. We believe, from our brief efforts, that mortality rates can be significantly lowered and that through a systematized selection process, intensive rehabilitation pays dividends. This has led to a volunteer training program in stroke resocialization designed to help the discharged stroke patient readjust to his community involvement.

A number of small projects were developed during this period aimed at continuing education for professionals in a variety of disease categories. Kidney disease was added to the Regional Medical Program by Congress during the recent extension of the program. A regionwide committee was developed, composed of leaders in the renal disease field, whose stated purpose was to develop a fully regionalized program. Projects were begun to improve and assure equal distribution of renal dialysis capabilities, to increase transplantation capabilities, to collect and store organs, and to improve the use of available drugs. Also, an information and patient registry system design was begun. It appears that the development of treatment in renal disease is at a point where complete regionalization could be accomplished more easily than with most disease categories.

Also, programs have been developed to increase physician knowledge about chronic respiratory disease. Aimed at improving skills in diagnosis, management and treatment as well as a better distribution of the service, an extensive evaluation effort is planned. Like renal disease, the respiratory disease efforts are of recent vintage, at least as to funding. Other programs have been devoted to information and referral services for patients who have special problems in order to reduce the time and effort entailed in random searching for help. Medical audit programs have been organized to aid community hospitals in developing a means to assess the quality of patient care and thereby assess the educational needs of staff and personnel. Comprehensive programs for neonatal care have been set up, and at least partially funded, for the purpose of reducing neonatal mortality through a systematic method of identifying high-risk patients and the use of physiological monitoring during the perinatal period. Several programs designed to regionalize and upgrade emergency medical services have been developed and are awaiting funding.

In addition, several small programs have been formed to bring services to areas that are underserved medically. The Fresno County Medical Society, jointly with RMP, developed a program to bring services to the Mendota-Firebaugh area in western Fresno County. Since RMP cannot provide direct patient care funds or services, means had to be found to cover service costs outside RMP resources. RMP provided the planning resources and the management capabilities, and organized the delivery system. The California Medical Association contributed $10,000 early in the planning stage to get the project under way. The services should become available later this year. Other rural clinics have been established, especially to provide services for remote Indian tribes and other isolated groups, where means could be found to pay for the services. All in all, RMP has spent relatively few program dollars on this kind of effort, but staff and study time has been considerable because of the complicating problems of community concurrence and service financing.

Since the beginning, California RMP has been engaged in creating consortiums of health manpower education. This is simply the drawing together of existing efforts in the health manpower training area, comparing the existing effort with the total need and attempting to fill in the training gaps by creating new training programs. Put another way, it is an attempt to systematize the rather sporadic training efforts that are characteristic of the health field. When the concept of Area Health Education Centers (AHEC) was unfolded as a national health goal, it was obvious that RMP would serve as a natural catalyst for their development. During the past year, California RMP has led the way in AHEC planning. These are designed as community based consortiums which will have the ability to assess the actual need for manpower and have the capability to fulfill these needs through existing institutions.

In summary, although our target groups may change slightly from time to time and old concepts are sometimes called by new names, the process remains the same. The national legislation for Regional Medical Programs, plus the initial planning for its activities in California, have been based on the premise that the best way to achieve success is through a process of regionalization. CCRMP reaffirms this position. Regionalization is achieved through cooperative working arrangements among various available health resources resulting in the maximum quality and quantity of health programs in a defined geographical area. The basic ingredients of regionalization are involvement, identification of needs, assessment of resources, definition of objectives, setting of priorities, implementation and evaluation.